COMMUNITY SCHOOL OF MUSIC AND ARTS

Consent to Participate, Release, and Medical Authorization

Please print clearly and return to CSMA at the address below

Name of Minor Child _____ Date of Birth _____ Age _____

I/We, the undersigned parent(s) or legal guardian(s) of the above-named minor, know that I may not be available to authorize medical care of said minor child and I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give The Community School of Music and Arts staff and faculty (herein referred to as CSMA) the right to give consent to authorize emergency medical care.

It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization relieve the physician, dentist, person rendering such care at the hospital or institution in which such care is given, from any liability resulting from the failure of me, the parent or guardian of the above-named minor, from signing a consent or authorization to render such care. It is the intent that CSMA shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by CSMA. I understand that this form is in effect from the date signed and that it is my responsibility to inform CSMA of any changes to this form. **It is my understanding that this form also serves to establish my consent and permission for the above-named minor to participate in CSMA programs, private instruction, and courses, and to be photographed or otherwise audio/visually recorded for use by CSMA in advertising and public relations.**

Check here if photographing/recording consent is NOT given _____

Please Print

Parent/Guardian Signature:_____ Date:_____

Print Name:_____ Home phone:_____

Work phone:_____ Cell phone:_____

Mailing address: _____City/State/ZIP:_____

Other Parent/Guardian Signature:_____ Date:_____

Print Name:_____ Home phone:_____

Work phone:_____ Cell phone:_____

Mailing address: _____City/State/ZIP:_____

Date of minor's latest tetanus shot:_____ List current medications:_____

List any allergies: _____ _____

_____ _____

Medical history or other important fact that should be known: _____

_____

_____

330 East State Street Ithaca, NY 14850 (607) 272-1474 Fax (607) 275-0994